SM Exhibit I

CONSULTATION REFERRAL
MEDICAL DIVISION
PD[429-180 (Rev. 8-00)] Print

SOCIAL SECURITY #			
DATE	MED DIST. #	CLINIC #	
RANK	NAME (LAST, FIRST, M.I.)		
COMMAND	TAX REGISTRY #	COMMAND PHONE #	
ON SICK REPORT ☒ YES ☐ NO	LINE OF DUTY ☐ YES ☐ NO	DATE OF LINE OF DUTY	CONSULTATION SPECIALTY
DOCTOR TO WHOM REFERRED:		APPOINTMENT DATE & TIME	NOTIFIED BY:

REASON FOR REQUEST / SPCIFIC QUESTIONS TO BE ANSWERED: (IF OTHER THAN THOSE LISTED BELOW)

NAME OF REQUESTING SURGEON (Printed) | SURGEON'S SIGNATURE

CONSULTANT'S REPORT - **PRINT OR TYPE** ANSWERS TO ALL QUESTIONS CHECKED, IF ADDITIONAL SPACE IS REQUIRED, USE REVERSE SIDE.

☐ **DIAGNOSIS:**

☐ **TREATMENT RECOMMENDED:**

☐ **PROGNOSIS:**

☐ **DUTY CAPABILITY: (INDICATE ACTIVITIES TO BE EXCLUDED)**
☐ CONTINUE ON SICK REPORT ☐ LIMITED CAPABILITY ☒ RESTRICTED DUTY ☐ FULL DUTY

☐ APPROX. RETURN TO DUTY?
☐ DO YOU WISH TO SEE THIS PATIENT AGAIN? ☐ YES ☐ NO. If so, when?

DATE	CONSULTANT'S NAME (PRINTED)	SIGNATURE

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